SPEC-B FORM

(Statement of Treating Physician, Required by RSMo 622.555)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

STATEMENT OF TREATING PHYSICIAN, FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES P.O. BOX 893 JEFFERSON CITY, MO 65102-0893	IF ASSISTANCE NEEDED, CALL: 573-522-9001 OR Toll Free at 1-866-831-6277 FAX 573-751-4354

SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant).

DRIVER-APPLICANT'S FULL NAME			
RESIDENCE ADDRESS			GENDER (Please check one box) ☐MALE ☐FEMALE
CITY	STATE	ZIP	DATE OF BIRTH
(AREA CODE) HOME TELEPHONE # ( )	(AREA CODE) WORK PHONE # (IF ANY) ( )	SOCIAL SECURITY #	
DRIVER'S LICENSE #	STATE WHICH ISSUED	DATE ISSUED	EXPIRATION DATE

SECTION 2. IDENTIFICATION OF TREATING PHYSICIAN

TREATING PHYSICIAN'S BUSINESS NAME		BOARD CERTIFIED ☐ YES ☐ NO
TREATING PHYSICIAN'S FULL NAME		BOARD ELIGIBLE ☐ YES ☐ NO
BUSINESS ADDRESS		
CITY	STATE	ZIP
(AREA CODE) OFFICE TELEPHONE # ( )	(AREA CODE) OFFICE FAX # ( )	PROFESSIONAL CERTIFICATION #
NAME OF CERTIFYING ORGANIZATION		PROFESSIONAL LICENSE #
ADDRESS OF CERTIFYING ORGANIZATION		
CITY	STATE	ZIP

SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN

A ☐	PLEASE GIVE A BRIEF DESCRIPTION OF THE APPLICANT'S MEDICAL CONDITION FOR WHICH A SKILL PERFORMANCE EVALUATION CERTIFICATE IS NECESSARY. ←CHECK BOX TO CONFIRM COMPLETION.

B ☐	IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT? ←CHECK BOX TO CONFIRM COMPLETION.	
☐ YES - HOW LONG?		☐ NO - EXPLAIN:

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.

SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN *(Continued)*

C ☐ IS THE TREATING PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH CONSULTATION WITH ANOTHER PHYSICIAN WHO HAS TREATED THE APPLICANT?

☐ YES | PHYSICIAN'S NAME | BUSINESS ADDRESS

CITY	STATE	ZIP	(AREA CODE) BUSINESS TELEPHONE #
			( )

☐ NO - EXPLAIN:

D ☐ DOES THE APPLICANT HAVE THE ABILITY AND WILLINGNESS TO FOLLOW ANY COURSE OF TREATMENT PRESCRIBED, INCLUDING THE ABILITY TO SELF-MONITOR OR MANAGE THE MEDICAL CONDITION?

☐ YES ☐ NO - EXPLAIN:

E ☐ IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY?

☐ YES ☐ NO - EXPLAIN:

F ☐ IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION LIKELY REMAIN STABLE OVER THE LIFETIME OF THE DRIVER-APPLICANT?

☐ YES ☐ NO - EXPLAIN:

SECTION 4. TREATING PHYSICIANS CERTIFICATION AND VERIFICATION

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION, AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

TREATING PHYSICIAN'S NAME (Printed)	DATE SIGNED:
TREATING PHYSICIAN'S SIGNATURE	

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